Health Information Technology Commission
Meeting Minutes

Date: Thursday, February 19, 2009
1 – 4pm

Location: MDCH
1st floor Capital View Building
Conference Room B&C
201 Townsend Street
Lansing, Michigan 48913

Commissioners Present:

Joseph Hohner
Toshiki Masaki – Vice Chair
Jeanne Strickland
Larry Wagenknecht, R.Ph.
Ken Theis
R. Taylor Scott, D.O
Janet Olszewski
Mark Notman
Kimberly Ross - Jessup
Tom Lauzon

Commissioners Absent:
Greg Forzley, M.D. – Chair
Robert Paul
Robin Cole

Staff:
Kurt Krause– MDCH
Beth Nagel – MDCH
George Boersma – MDIT

Guests:
John Hazewinkel – MSU
Dana Green – Altarum
Amy Smith - MSU
Matt Monroe – Altarum
Kelly Coyle – MPHI
Jeff Shaw – MPHI
Mindy Richards – ChangeScape
Larry LaCombe – ChangeScape
Tom Stevenson, DO – Covisint
Tim Pletcher – MiHIA
Robert Brown – KCMS
Denis Couture – ChangeScape
Sharon Emery – Rossman Group
Anya Day – Altarum
John Christensen – Altarum
Robert Jackson, MD, - SEMHIE
Steve Neal – HIE of NM
Elizabeth Gertz – HIE of NM
Karen Schmidt – MHIMA
Nancy Walker – MHIMA
Tricia Smith – Temple Trak
Mick Talley – SEMHIE
Lody Zwarensteyn – AFH
Leland Clark – AFH
Mary Anne Ford
Jim Lee, MHA
Ann Lemerand, RecWare
Virginia Minolla – Emprical Solutions
Marcus Cheatham – Ingham Co.
Pam Stott, Medicity
Sharon Leenhouts, MiHIA
Linda Mcardel, MPHI
Jackie Rosenblatt, MPRO
Kelly Amalfitano, CBS

Agenda:

A. Welcome – Toshiki Masaki
- Filling in for Greg Forzley, chair
- Overview of meeting

B. Vote on Public Input Guidelines
- Toshiki Masaki went through the guidelines for input and the HIT Commission voted all in favor of the input guideline

Action by the HIT Commission

VOTE: to support the following public input guidelines:

Before Speaking
- All speakers will speak in the order they arrived and were provided a number card
- All speakers must fill out and return an identification card before speaking
- All speakers must speak into the microphone and give their names and affiliation

While Speaking
- All comments should be addressed to the HIT Commission, should be relevant to the proposed recommendations, and should not be of a personal nature.
- To maximize time, all speakers will have 5 minutes to deliver input
- Commissioners may choose to ask questions for a maximum time of 2.5 minutes

Written Testimony
- Written testimony collected prior to the meeting has been distributed to the Commission.
- Written testimony/supporting materials that have not yet been collected will be distributed during a speakers input time.

RESULT: (8 Commissioners Present) **8 votes in favor, 0 opposed**

C. Purpose of the Public Input Meeting

- Toshiki Masaki, Vice-Chair, discussed the purpose of the meeting and the goals that the Commission is seeking to accomplish. The Vice Chair went through a slide set that assisted in explaining the purpose of the meeting
- Kimberly Ross-Jessup noted that already in the written testimony there is a strong lack of consensus. Ross-Jessup stated that in the written testimony there are some strong opinions for centralization and some strong opinions for a very local approach. Ross-Jessup stated that today's meeting is very important for the Commission to sort out this issue.

D. Public Input

- A summary of the public input was provided by the following people is attached to the meeting minutes:
    - Mindy Richards, ChangeScape
    - Donna Roach, Bronson
    - Dan Armijo, Altarum Institute
    - Robert Jackson, MD, SEMHIE Chair
    - Steve Neal, HIE of Northern Michigan
    - Elizabeth Gerts, HIE of Northern Michigan
    - Helen Hill, HFHS, HIMSS, SEMHIE
    - Tom Stevenson, DO, Covisint
    - Mick Talley, University Bank
    - Lody Zwarensteyn, Alliance For Health
    - Jim Lee, MHA
    - Tim Pletcher, MiHIA
    - Marcus Cheatham, Ingham County Health Department
    - Jackie Rosenblatt, MPRO

- Janet Olszewski and Toshiki Masaki noted that more input needs to be given on the recommendations that the HIT Commission put forth prior to the meeting.
- Olszewski and Masaki asked the people who provided public input to answer what types of roles and responsibilities should be local and which should be central. They also asked for more input on what the business plan should be for statewide and local systems.
- There was no immediate response from the audience, so Masaki asked that those with ideas submit those to the Commission before the March 4, 2009 meeting.

E. Adjourn

- Adjourned at 3:23pm.

Public Input Log
HIT Commission
February 19, 2009

#	Name	Affiliation	Comment Summary	Commissioner Question	Response
1	Mindy Richards	Change Scape	SWMHIE - people matter, leverage standards, regional value, a public/private partnership model. The state can create standards and continue regional funding. The regions can build upon previous efforts and do community work to get stakeholder buy-in		
	Donna Roach	Bronson	draw from regional experience and that of other states: close scrutiny of centralized system, leverage private/public partnership, capitalize on momentum, current standards, governance structure and more than one vendor	TM: What could be centralized? Can an MPI be centralized?	you need to look at what is given up at regional level and taken over at the centralized level. Look at who gains and look at who gets value. Centralized doesn't always save money in the end. Standardization doesn't always make sense for small facilities. Core technology at what level? Can the regions add pieces to the MPI?
2	Dan Armijo	Altarum	HIEs have been struggling with sustainable business plan - alignment with costs and benefits are disconnected. HIE has a big payoff, but it is disbursed throughout the system. We will need to make a paradigm shift by changing patient/provider roles. Impact of internet on e-shopping - expanded information, expanded consumer info, empowered to make better choices. We want to see this happen in healthcare. We need to look at regional and centralized together	TM: does altarum have recommendations on central v. regional	MPI has to be centralized, and there are economies of scale that can be realized. Doesn't know if centralized is too risky, look at scalability

Rob Jackson	SeMHIE - family physician	SEMHIE supports findings and recommendations and concur with other regions. The HIT Commission and regions must work together. SEMHIE has developed goodwill and trust and it has not been easy. We cannot lose some of the regional work - like trust, collaboration, cooperation and this cannot be scalable to the state level. We need clearly defined roles - clear detailed delineations of state v. regions roles, responsibilities. Certain functionality is suited for regions - recommend working sessions to determine appropriate division of labors. If we move too fast we'll leave groups behind. Regions must be integrated in the decision process.	KRJ: Has any of your experience captured what should be accomplished? Do you think we need to bring together all of the regions	We've all been working toward the regional goal. Now we may be working toward a statewide HIE. That is different. More complex, more people involved. There needs to be time for collaboration so that we do not make miss-steps.
Steve Neal	S2a- John Evans, NCC	We have 5 suggestions to submit in writing. Provide a statewide business plan, protect early adopters, reward organizations that make big commitments, leverage pub/private partnerships, require regions to secure direct and indirect contributions from within their regions, maintain skin in the game, empower and provide autonomy of regions, develop a statewide approach - offer infrastructure services, MPI, RLS, with local abilities to modify, minimum set of technology standards, core functionality, regions chose vendor solutions, avoid a one-vendor solution to meet the needs of each region, too high risk to put all eggs in one basket, manage the adoption/implementation at a local level, vendors are to respond to the regional leadership	KRJ: should funding and revenue should be shared between the regions and the state? KRJ: Should state give guidance on vendors? TS: what is an incentive for an early adopter?	Yes, regions should have on-going plans to do specific work about who benefits and how. Beneficiaries should be contributing. Difference between state funds and local revenues should be separate. We'd like to see a partnership between regions and the state to set standards. We need input from around the state. We need a collaborative effort, but I wouldn't buy one vendor only. if a region is ready to go - willing to pull out their checkbook - state funds should go to them and doesn't get put into a competitive grant. If a region is ready, then just give them the money and fast track it. We are losing credibility with CEOs b/c scope keeps changing.

	Elizabeth Gertz	North Central Council of Hospitals	Region has not experienced the barriers that are outlined in the document - has a planning grant and has achieved many of the goals. All major provider and employer stakeholders completely on-board, approach meets maximum value, met all goals, approved for an implementation grant pending modification, final business plan submitted, Followed Conduit to care, best practices from the resource center, reduced vendor costs, expanded functionality, secured significant funding, We are "shovel ready". vendor evaluation, momentum is critical, we need to ensure credibility among stakeholders, local control over implementation is key, interface economy of scale, Request that the State of Michigan approve funding	MN: Momentum has stalled? What does that mean? TM: What does the other thirds come from? JO: Has BCBSM agreed to pay?	Momentum has stalled b/c we have yet gotten money from the State of Michigan. Vendor negotiations were wrapped up in the fall, payer support has waned. Hospitals and physicians are one-third of the funding in the business plan. No written response from BCBSM, which is a third of the business plan, but they said they are interested. State of Michigan is another third of the plan
8	Helen Hill	HIMSS, , Henry Ford Health System, SEMHIE	We strongly support a federated model without any centralized, access to each regions data must be kept local with secure standards We can link to national and regional efforts through a trust exchange. Also, a federated approach provides multiple solutions and multiple vendors, which encourage innovation. I also suggest a pub/private partnership to create a new entity state, investors, regions. Cross-industry collaboration should be encouraged. Must incorporate lessons learned from current project. Give regions a stake in governance.	TM: when you say multi-vendor solutions, are you talking about incorporating systems or just applications JO: What do you think of the draft the commission is set forward? MN: What would be in a central system?	Health systems have big investments: regionally and nationally. Many health systems have results delivery for their own doctors. Each system has different products. We can encourage functions, but not specific vendor solutions. _ We support many of the recommendations, however, we are not sure what a common backbone means. We would be pleased to meet and vet solutions to come up with something common - solutions and governance that would balance the needs with the regions. The only data that should be kept centrally is just enough to uniquely identify a patient
9	Tom Stevenson	Covisint	Covisint can work in any atmosphere that is chosen. Some centralized features can be done and still regions can be kept too. Several keys to physician adoption success: 1 - beneficial to patients, 2 - null or positive effect on clinical efficiency, 3 - minimal to no effect on bottom line of a practice, 4 - must have choice. A single application is thrown out, they won't adopt it uniformly. EMR adoption will not get us there alone.	TM: What type of decision should be left up to the doctors? JO: Docs don't have to buy a full-on EMRs - could they buy portals and get reimbursed?	Modular approach - portal solutions, physicians can chose whatever applications that they want without investing much _ Yes, that is how I understand it

11	Mick Talley	University Bank	Privacy & Security cannot be bought off the shelf. HIE should be a neutral site that processes multiple solutions from front end to back end. We need to offer services to the community. Privacy and Security is a pre-condition before applications are rolled out. three parts to PRIVACY AND SECURITY policy. The state should play a regulatory role. On the policy level, it would useful if the state could consider a database where we can access HIPAA rules and regulations.	TM: What is a conflict point if the state has a centralized MPI and the architecture you have worked on?	There isn't one as long as the HIE is a neutral site for many different functions.
12	Lody Zwarenstien	Alliance For Health	We would have liked the Commission to have worked with the regions to construct the recommendations. Statewide business model makes sense. MPI/RLS is desirable. Human capital cannot be deleted and would be jeopardized in a top-down approach. Local functions should be allowed to have options for applications. There is always going to be pushback on a system. Statewide system is jeopardized by scalability. Statewide standard setting is helpful. legislative mandate is not helpful and is contrary to the MiHIN goals	JO: what do you mean by some statewide functions?	State could do some interfacing. Legal aspects, patient identifiers, and ideally, the resource center should be helping at the local level and helping at the state level - sharing of experience.
14	Jim Lee	MHA	Healthcare is delivered locally - by 80%. The state should focus on value-adds not replacements. What can the state provide to enhance not replace. Economy has not changed. Technology was not a focus of the Conduit to Care. Expertise resides in the regions, not at the state, not in the Commission. Continue to use the Conduit to Care report.	TM: Can we build on a central MPI/RLS? Does that have to be regional? Conceptually JO: Are you saying we should have redundant systems? JO: How do you respond to investors who see redundancy as unnecessary?	Conceptually, yes, there is economies of scale for an MPI/RLS centralized. Networks only work as well as the hub - so if we have a single hub, what if it fails? What are the consequences of the economies of scale? Redundant systems are important. _ Healthcare is redundant. It is part of the process. HIE is not going to solve all of the issues with healthcare. Probably not a big value proposition for redundancy. Some providers will struggle with making that investment, but they are better off with a redundant system than with what we have now.
15	Tim Pletcher	MiHIA	Economies of scale are important to discuss. Aggregate purchasing power not technical solutions. We could purchase together and get economies of scale on an MPI for the state and for each region. State must have MPI to organize all of its own components. Considerable investments in pub/private partnerships. A "left turn" could erode our progress. Trust is hard-won and we have to be trusted in order for HIE to work. Security has to be done right at the center.	None	None

16	Marcus Cheatham	Ingham County Public Health	We must look at what is working in the market place as well as our own criteria. Look at functionality that is already successful - open to learning. Must provide value to providers so that they can justify their fees.	LW: Do you see any ways in which the state can assist in the business plan? Some standardization or is it purely local? JO: Who pays and how much do they pay? LW: Business plan is the hold-up. It is hard to get everyone to agree on a business plan? JO: Put yourself in the shoes of a statewide organization that is subject to many different business plans? JO: A more consistent approach on how people pay and play. How does that affect the ability to move this forward and sustainability? TS: Is there enough value for a statewide player to come to the table?	Technological and leadership role should come from the Resource Center. The Resource Center should be providing more hand holding to develop the business plan in each community. Facilitation on getting agreement in the business plan is important. Enormous economies of scale in building a statewide solution. I would consider the option of looking at the business case for a statewide solution. There is a lot of risk involved in selecting a vendor.
19	Jackie Rosenblatt	MPRO	Practices are at different levels and we need to be sure to provide assistance in physicians offices. We have to provide training. Regardless of solutions, we have to be able to provide help.	JO: specific recommendations on how that would take place?	yes, state take a leadership role in making sure there are requirements for providing assistance. The state should provide DOC-IT type of assistance and should use state funding. Must be clear types of assistance.